

2169

CERTIFICATE OF DEATH

Reg. Dist. No.

762

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				d. STREET ADDRESS R.F.D. # 1 Box 90		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Salbert William Dickerson				4. DATE OF DEATH Month February Day 11 Year 1957			
5. SEX M.	6. COLOR OR RACE O.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1909		9. AGE (In years lost birthday) 47 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Dickerson				14. MOTHER'S MAIDEN NAME Hattie Corbin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-09-4205		17. INFORMANT Martha Dickerson 1328 Shields Place Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Hemorrhage DUE TO (c) Pulmonary Tuberculosis							INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 6 mts
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 581.1 Lacunar's Cirrhosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from 1/15 , 19 57 , to 2/11 , 19 57 , that I last saw the deceased alive on 2/11 , 19 57 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Cecil A. Deverney M.D.				ADDRESS (Street, city or town, state) 801 - 4th St, Pocomoke, Md. DATE SIGNED 2/14/57			
PHYSICIAN'S NAME (Type) Cecil A. Deverney							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/17/57		22c. NAME OF CEMETERY OR CREMATORY Tindley Chapel		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Md.				ADDRESS 4th St, Pocomoke, Md.		24a. REC'D BY REGISTRAR FEB 20 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. Deville Lyman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG211 2-25-57et

02181

2170

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE MD		c. LENGTH OF STAY IN 1b 13 YEARS		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE MD X 2		d. STREET ADDRESS 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) IRVIN ROBERT GRANT SR		4. DATE OF DEATH Month 2 Day 14 Year 1957		
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/1883	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER		10b. KIND OF BUSINESS OR INDUSTRY HOTEL		
11. BIRTHPLACE (State or foreign country) CHARLESTON S.C.		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME WILLIAM GRANT		14. MOTHER'S MAIDEN NAME CHARLOTTE BROWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT IRVIN R. GRANT JR. PRINCESS ANNE MD.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Senility				INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Virus Respiratory tract infection				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan 22, 1957 to Feb 14, 1957 , that I last saw the deceased alive on Feb 14, 1957 , and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE A.C. Lewis M.D. ADDRESS (Street, city or town, state) Princess Anne, Md DATE SIGNED 2/18/57				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/17/57		
22c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY		22d. LOCATION (City, town, or county) (State) PRINCESS ANNE MD		
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones Jr		24a. REC'D BY REGISTRAR R. E. Johnson		
24b. REGISTRAR'S SIGNATURE R. E. Johnson		DATE 2-18-57		

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02182

2166

CERTIFICATE OF DEATH

Reg. Dist. No.

265-

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ed. McCready Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fredrick Handy Hall</u>		4. DATE OF DEATH Month Day Year <u>2 20 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hydrating Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marion Station</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Handy Hall</u>		14. MOTHER'S MAIDEN NAME <u>Loviz Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>214-03-7544</u>	
17. INFORMANT Address <u>Hattie Hall Marion Sta., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Condition - Pulmonary defect</u> <u>550.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Peritonitis due to appendicular chole</u> DUE TO (c) <u>6 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute appendicitis with peritonitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 14, 1957</u> , to <u>2-20-1957</u> , that I last saw the deceased alive on <u>2-19-1957</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Marion Sta., Md.</u> <u>2-22-57</u>			
ACTUAL SIGNATURE <u>George C. Coulbourn</u> M.D.			
PHYSICIAN'S NAME (Type) <u>George C. Coulbourn M.D.</u>		MARION STATION - MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. PEER WARD</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Som. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-22-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 21

FEB 25 1957

RECEIVED

2171 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edw. McCready Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Asbury</u> First <u>S.</u> Middle <u>Howard</u> Last				4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 22, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Stephen Howard</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>217-36-0986</u>		17. INFORMANT <u>Mrs Cecil M. Howard, Kingston, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Condition - Hypertension</u> <u>550.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia - Acute appendicitis</u> DUE TO (c) <u>Virus Pneumonia Feb. 1 to Feb. 14 - 1957 -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>7 days</u> <u>13 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Appendectomy Feb. 19 - 1957 -</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 18, 1957</u> , to <u>Feb. 25, 1957</u> , that I lost saw the deceased alive on <u>Feb. 25, 1957</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George C. Coulbourn</u> M.D.				ADDRESS (Street, city or town, state) <u>Marion Sta. Md.</u> DATE SIGNED <u>2-27-57</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE C. COULBOURN-M.D.</u>				MARION STA. MARYLAND.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rehoboth, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-27-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mellie D. Payne</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

PLACE OF DEATH		DATE OF DEATH	
AT HOME		MARCH 1, 1957	
DECEASED'S NAME		MRS. J. M. SMITH	
AGE		65	
SEX		F	
RACE		W	
EDUCATION		H	
OCCUPATION		H	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		N	
SIGNATURE OF PHYSICIAN		J. M. SMITH	
SIGNATURE OF REGISTRAR		J. M. SMITH	
SIGNATURE OF WITNESSES		J. M. SMITH	
SIGNATURE OF DECEASED		J. M. SMITH	
SIGNATURE OF NEXT OF KIN		J. M. SMITH	
SIGNATURE OF BURIAL OFFICIAL		J. M. SMITH	
SIGNATURE OF MINISTER OF THE GOSPEL		J. M. SMITH	
SIGNATURE OF CHURCH CLERK		J. M. SMITH	
SIGNATURE OF FUNERAL HOME		J. M. SMITH	
SIGNATURE OF CEMETERY		J. M. SMITH	
SIGNATURE OF INTERMENT		J. M. SMITH	
SIGNATURE OF BURIAL		J. M. SMITH	
SIGNATURE OF CREMATION		J. M. SMITH	
SIGNATURE OF OTHER		J. M. SMITH	

RECEIVED
MAR 1 1957
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02184

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Hill		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Hill		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Johnnie Middle Johnson Last Johnson				4. DATE OF DEATH Month February Day 3 Year 1957			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1903		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 3 Days 3	IF UNDER 24 HRS. Hours 3 Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cris Johnson				14. MOTHER'S MAIDEN NAME Alverta Waters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222-05-4634		17. INFORMANT Mamie		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Coronary Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH few minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. H. Johnson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED Feb 6 - 1957
EXAMINER'S NAME (Type) R. H. Johnson, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-57		22c. NAME OF CEMETERY OR CREMATORY Clemtainers Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Upper Fairmount, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar W. Hartner				ADDRESS New Church, Va.		24a. REC'D BY REGISTRAR 7-6-57	
				24b. REGISTRAR'S SIGNATURE R. H. Johnson, M.D.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be returned to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MASSACHUSETTS AND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 8 1957

RECEIVED

2173

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital				d. STREET ADDRESS 228 Broadway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) NETTIE		First NETTIE		Middle TAYLOR		Last MORGAN	
4. DATE OF DEATH		Month February		Day 17		Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1906		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Bloxom, Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Taylor				14. MOTHER'S MAIDEN NAME Jeanette Muirs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas A. Morgan--228 Broadway--Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Chronic Cardiac Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 16, 1957 , to Feb. 17, 1957 that I last saw the deceased alive on Feb. 17, 1957 , and that death occurred at 1 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Sarah M. Peyton		M.D. Crisfield, Md.		ADDRESS (Street, city or town, state) Main St.--Crisfield, Md.		DATE SIGNED 2/18/57	
PHYSICIAN'S NAME (Type) Dr. Sarah M. Peyton							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Mariners Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 2/23/57	
				24b. REGISTRAR'S SIGNATURE Barbara L. Hildner			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		CITY OF BIRTH [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]	
MARRIAGE [Illegible]		RELIGION [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

BUREAU V. 2

FEB 28 1957

RECEIVED

2174

CERTIFICATE OF DEATH

Reg. Dist. No.

02186

365

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AGNES Middle VIRGINIA Last POWELL		4. DATE OF DEATH Month February Day 6 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 7, 1898
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Garment Mfg.	
11. BIRTHPLACE (State or foreign country) Tangier, Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Crockett		14. MOTHER'S MAIDEN NAME Sadie Marsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-8860	
17. INFORMANT Claude Crockett--Rt. #1--Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TOXIC MYOCARDITIS & PERICARDITIS 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA DUE TO (c) CORONARY INSUFFICIENCY & CONGESTION PASSIVE		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 1 MONTH 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OBESITY AND HYPERTENSION IN PAST		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-25, 1952 , to 2-6, 1957 , that I last saw the deceased alive on 2-6, 1957 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Q. N. Barr, M.D. 2-12-57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. A. N. Barr Main St.--Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR DATE 2/28/57	
24b. REGISTRAR'S SIGNATURE Barbara S. Adams			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 5 1957

RECEIVED

2175

CERTIFICATE OF DEATH

Reg. Dist. No.

267

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William F. Pusey				4. DATE OF DEATH Month February Day 5 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1888		9. AGE (In years lost birthday) yrs. 68	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Emory Pusey				14. MOTHER'S MAIDEN NAME Virginia Townsend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Miss Dorothy Pusey, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 1, 1956 , to Feb. 5, 1957 , that I last saw the deceased alive on Feb. 5, 1957 , and that death occurred at 6:30 a. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles W. Trader				ADDRESS (Street, city or town, state) Pocomoke City, Md.			
DATE SIGNED Feb. 6, 1957							
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-57		22c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery		22d. LOCATION (City, town, or county) (State) Rural Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR FEB 7 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. Conville Boyman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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BUREAU V. S.

FEB 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2176

CERTIFICATE OF DEATH

Reg. Dist. No. 560

02188

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne x1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.S.H. # 2</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Alice</u> Last <u>Ross</u>				4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 22, 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James W. Givens</u>				14. MOTHER'S MAIDEN NAME <u>Sarah R. King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Bruce Princess Anne Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>420.1</u> DUE TO <u>LONGESTIVE HEART FAILURE (RIGHT + LEFT SIDED)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY OCCLUSION WITH</u> (c) <u>INFARCTION (MYOCARDIAL); ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>ONE HOUR</u> <u>? 2 WEEKS?</u> <u>2 WEEKS?</u> <u>33 YEARS?</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OBESITY; HEPATIC DAMAGE; NEPHROSCLEROSIS(?)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>FEB. 2</u> , 1957, to <u>FEB. 13</u> , 1957, that I last saw the deceased alive on <u>FEB. 13</u> , 1957, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Geo M. Dunn</u> M.D.				ADDRESS (Street, city or town, state) <u>PRINCESS ANNE, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE M. DUNN M.D.</u>				DATE SIGNED <u>2-14-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Givens</u> ADDRESS <u>Princess Anne Md</u>				24a. REC'D BY REGISTRAR <u>R.S. Johnson</u> DATE <u>2/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>M.D.</u>	

100-443886-100

FEB 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02189

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY in lb since birth		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gandy Ave.				d. STREET ADDRESS Gandy Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VANESSA Middle GALE Last SCOTT				4. DATE OF DEATH Month February Day 12 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1956		9. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR Months 2 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Lee Scott				14. MOTHER'S MAIDEN NAME Stella Mae George			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Joseph Lee Scott--Gandy Ave.--Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Whooping Cough 056.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Possible Pnuemonia, according to symptoms DUE TO (c) No medical treatment desired by family						INTERVAL BETWEEN ONSET AND DEATH 3 weeks ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Wm H Coulbourn				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. William H. Coulbourn				DATE SIGNED Feb. 13, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.				ADDRESS Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR DATE 2/16/57	
				24b. REGISTRAR'S SIGNATURE Barbara S. Adams			

5000203XV5

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - SANITATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple fields for medical examination and death certification, including sections for cause of death, manner of death, and examiner's signature.

RECEIVED
FEB 25 1957
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02190

2177

CERTIFICATE OF DEATH

Reg. Dist. No. 360

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ORIOLE MD			c. LENGTH OF STAY IN 1b LIFE TIME			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 ORIOLE MD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARTHA Middle B Last SELBY				4. DATE OF DEATH Month 2 Day 16 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/1881		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) ORIOLE MD.		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME GEORGE JONES				14. MOTHER'S MAIDEN NAME HANNAH SULLIVAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address HAROLD SELBY ORIOLE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 24 hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X Hypertensive cardiovascular disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-7-55 , 19 56 , to 2-16-57 , 19 57 , that I last saw the deceased alive on 2-16-57 , 19 57 , and that death occurred at 1:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Everett C. Sutter M.D.				PHYSICIAN'S NAME (Type) Everett C. Sutter MD Dames Quarter, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/19/57		22c. NAME OF CEMETERY OR CREMATORY ST JAMES		22d. LOCATION (City, town, or county) (State) PRINCESS ANNE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md.				24a. REC'D BY REGISTRAR DATE 3/18/57		24b. REGISTRAR'S SIGNATURE K.S. Johnson, m. n. g.	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Date of registration		12. Initials of registrar	

BUREAU V. 5

FEB 20 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2168

CERTIFICATE OF DEATH

Reg. Dist. No. 265

02191

1. PLACE OF DEATH o. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> x0	
c. LENGTH OF STAY IN 1b <u>8 yrs.</u>		d. STREET ADDRESS <u>R.F.D. 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cornelius T. Ward</u>		4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Crisfield - R.F.D. 2</u>		12. CITIZEN, OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ward</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-7603</u>	
17. INFORMANT <u>Nellie Morgan</u> Address <u>Crisfield, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1957</u> , to <u>Feb 10, 1957</u> , that I last saw the deceased alive on <u>Feb 9, 1957</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D. <u>Crisfield, Md.</u> <u>2/12/57</u> PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/13/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, R.F.D. 2 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. H. Ward</u> ADDRESS <u>Marion St., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2/12/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Barbara S. Adams</u>			

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FEB 18 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke (Rural)</u>		c. LENGTH OF STAY IN 1b 	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D.# 1</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Pocomoke (Rural)</u>	
f. STREET ADDRESS <u>R.D.# 1</u>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>GLENN</u> Last <u>WILSON</u>			
4. DATE OF DEATH Month <u>February</u> Day <u>14th</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 17, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Somerset Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William John William Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Laura Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Address <u>Mrs. Anna G. Wilson (Wife) R.D.#1 Pocomoke, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burned by fire - Body charred</u> DUE TO <u>Both lower legs destroyed</u> Conditions, if any, which gave rise to immediate cause (b) <u>Home burned - could not escape</u> (c) <u> </u> (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Home burned</u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour 4:00 p.m. 2-14 1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Pocomoke R. Somerset Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R.H. Johnson</u>		DATE SIGNED <u>Feb 15 - 1957</u>	
EXAMINER'S NAME (Type) <u>R.H. Johnson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 17, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>Feb 19 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Grille Byrnes</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 19 1957

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